HIV/AIDS Disease Management Pilot Program – RFP# 06-55519
Proposer Comments/Questions and Responses
OFFICIAL – October 2, 2006

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1.	Appendix 2 and Data Methodology document in Data Library	1	The criteria for finding the eligible population only have one ICD 9 code, i.e., 042, which will only identify AIDS within the 21 Aid codes selected. Beneficiaries who are HIV, non-AIDS (ICD9 V08) will be excluded.	Proposer has developed an algorithm to identify people with HIV and AIDS for other Medicaid programs and is willing to share and explain its accuracy in inclusion of eligible enrollees.	An addendum will be issued to the RFP to include ICD-9 code V08 to the Primary and Secondary Diagnosis Criteria for the Eligibility Criteria Chart in Appendix 2. However, as noted in the Medstat Episode Grouper Methodology document in the data library, data library information was compiled using ICD-9 Codes 042 and V08.
2.			Proposer was not able to locate on the web site any documentation that CDHS will supply monthly claims information to the vendor so as to be able to perform the scope of work as outlined in Exhibit A.	Claims data are necessary to perform all aspects of DM, like decreasing ER visits, monitoring medication adherence, referral follow up, and regular monitoring of evidence-based HIVAIDS indicators. Proposer requests that CDHS state that claims data will be provided to the vendor monthly.	An addendum will be issued specifying that CDHS will provide the contractor with monthly claims data on enrolled members. This addendum will update Exhibit A, Scope of Work, D. Utilization Monitoring.
3.	In Exhibit A, Scope of Work, G. Member Services, 1. Outreach and Assessment, b. Assessment	15	The paragraph states "Assessment information may be compiled from various sources, including but not limited to . . . but shall not be obtained through the provision of face-to-face direct clinical medical services from the DMO." In order for an RN to	Please clarify whether face-to-face clinical assessment by DM RNs is forbidden by this sentence. If so, Proposer strongly urges CDHS to allow face-to-face assessment.	Face-to-face (F2F) assessment is not forbidden by this sentence but is meant to define the type and amount of contact with a member and/or potential member to conform to the Centers for Medicare and Medicaid Services definition of administrative case management services as

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			assess a patient, s/he must meet the patient and assess them face-to-face. This sentence seems to prohibit what Proposers experience shows is the most important aspect of an HIV/AIDS DM program.		defined in the State Medicaid Director Letter – January 19, 2001 and the State Medicaid Manual, section 4302.2. According to the State Medicaid Director Letter of January 19, 2001, Case management services can include Assessment which includes activities that focus on needs identification. Specific assessment activities include: taking client history, identifying the needs of the individual, and completing related documentation. The State Medicaid Manual, section 4302.2 , Part4, p.312, lists Medicaid eligibility determinations and redeterminations; Medicaid intake processing; Medicaid preadmission screening for inpatient care; Prior authorization for Medicaid services and utilization review; and Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system) as examples of activities which may properly be claimed as administrative case management activities.
4.	Exhibit A, Scope of Work, G. Member Services, 2. Enrollment/Disenrollment	15	The process of enrollment requires beneficiaries to opt in to the program. Various opt-in DM	All "potential members" on the monthly lists should be considered to be enrolled	CDHS cannot consider an opt-out approach for enrollment in the HIV/AIDS Disease Management Pilot

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			programs have demonstrated that opt-in programs do not work. Rather, opt-out programs allow the vendor time and resources to locate and enroll beneficiaries.	for 180 days at the full PMPM rate, giving the vendor the ability to locate and assess members. A reduced PMPM should be paid for another 90 days, at which time the member will be dropped from the rolls. Proposers experience is based on this opt-out model and the rate of enrollment and engagement is over 88%, compared to Medicare opt-in programs in the Midwest that had enrollment rates under 30%.	Program (DMPP). The CDHS office of HIPAA has issued parameters for outreach and enrollment as follows: The Medi-Cal DMPP may share very limited information with its Disease Management Contractor for the purpose of doing outreach and enrollment of HIV/AIDS infected beneficiaries into the DMPP, provided that: 1. The contractor first signs a Business Associate Agreement with Medi-Cal which includes information related to the penalties for breaching confidentiality of HIV/AIDS records as required by Health and Safety Code section 121025. 2. Only the minimum amount of information necessary for the contractor to make contact with potential enrollees is given to the contractor, before the HIV/AIDS patient actually enrolls and signs consent forms and authorizations to disclose confidential health information.

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					3. That the Disease Management contractor be prohibited from subcontracting the outreach/enrollment function because of restrictions on re-disclosures. An addendum will update Exhibit A, Scope of Work and Exhibit E, 29. Confidentiality of Information, to include this information.
5.	Exhibit A	21	Will providers/PCPs be required by CDHS to cooperate with the DM vendor?	CDHS should require that PCPs cooperate with the DM vendor.	There are currently no contractual agreements between CDHS and FFS providers that stipulate cooperation with DMPP as a condition of their Medi-Cal provider status.
6.	RFP Scope of Services and Exhibit A	23	The RFP and Exhibit A use the phrases "disease management" and case management interchangeably, including using the phrase "disease/case management" (see Scope of Services, p. 23 of the RFP). DM and case management (CM) are different services, the latter being more intensive, one-on-one facilitation of access to the health and social systems according the clinicians' orders. The intent of CM is to facilitate healthcare as	If CM is part of the vendor's responsibilities, then the fee structure that is proposed in the RFP is not appropriate because it is a risk structure. CDHS funds multiple CM programs (e.g., targeted CM, DOT, AIDS waiver) on a fee-for service basis. If CM is a part of this DM pilot project, then a portion of the fee should not be at risk.	The fee structure will remain the same as that currently presented in the RFP. CDHS recognizes the difference between DM and CM as evidenced by the definitions provided in the glossary (Appendix 1). CDHS also recognizes that there may be some overlap between DM services and CM services when dealing with multiple comorbidities and/or higher risk cases.

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			ordered by clinicians, not to promote patient self-management according evidence-based practice guidelines.		
7.	Exhibit A, Scope of Work, Members, 2, Enrollment/Disenrollment, c.8, p. 16 and Data Methodology document, a.ii.2. Aid Codes, p. 1	16,2	The former excludes from membership those eligible as "medically needy," while the latter lists six sub-categories of the medically needy as part of the database compiled for vendors to make informed bid. This is contradictory if the Aid codes are not to be used to identify eligible members. This issue is related to Item no. 1 above, where Proposer questions the use of only ICD9 042 to identify people with HIV or AIDS.	Please clarify whether the medically needy will be included in the monthly lists of eligibles.	An addendum to Exhibit A, Scope of Work, G. Scope of Services will be issued removing the reference to excluding medically needy from eligibility into the HIV/AIDS DMPP. There will be no change to the aid codes used to identify eligible beneficiaries.
8.	Exhibit A, Scope of Work, Member Services, 2, Enrollment/Disenrollment, c.10	16	People with HIV/AIDS in CM programs are ineligible for DM. CM and DM are not comparable services. See discussion in No. 6 above. The Proposer conducts DM activities and collaborates with CM agencies to assure positive outcomes. There is no crossover of services between proposer and Medicaid-reimbursed CM agencies.	Permit those beneficiaries enrolled in CM programs to participate in the DM pilot project.	No. The goals of DM and CM are similar and it would be difficult if not impossible to differentiate whether outcomes were the result of one program or another.
9.	Exhibit A, Scope of Work, Member Services, G.,	19	The requirement to "employ a licensed psychiatrist, psychologist	Remove this requirement from the Scope of Work	No. Exhibit A, Scope of Work, G. Member Services-Scope of Services

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	Member Services, 3.d., Disease/Case Management, d		or licensed/certified mental health specialist to address the behavioral or mental concerns of the member" indicates a face-to-face and medical relationship with an individual member. This is not a recognized function of DM programs.	because it creates an ongoing clinician-patient relationship for therapy. DM RNs would assess a member for mental health needs and include it in the ITP.	states that the contractor will develop policies and procedures to provide administrative disease/case management service. The definition of administrative case management services in the glossary precludes face-to-face contact for delivery of the underlying medical services. The requirement that the contractor employ the services of a licensed psychiatrist, psychologist, or licensed/certified mental health specialist, as needed, to address the behavioral and/or mental health concerns of the Member ensures that those concerns are managed by qualified medical staff.
10.	Exhibit B, Attachment 1/I, No. 8, Savings Guarantee	3	This section states that the DMO "shall guarantee to CDHS a zero percent increase in net medical costs for Medi-Cal who are eligible for the DM pilot project." First, there is no definition of net medical costs. HIV/AIDS therapy changes at least two times per year based on ongoing pharmaceutical and therapeutic studies. New drugs are also approved by the FDA that have an impact on the cost of care. HIV care has never been in the most	Only enrolled members should be included in the calculation of zero percent increases in medical costs. The first six months of the program should not be included in the calculation of the savings.	(Answer Pending)

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			optimal setting of zero percent increase. First, net medical costs need to be well-defined or all new therapies and pharmaceuticals need to be excluded from the savings calculation. Second, the same sentence bases the zero percent increase in medical costs to "eligible" members, some of whom will have not been enrolled and managed. Third, the DMO is at risk for full savings according to 8.A from start of the contract. During the ramp-up phases of new programs it is difficult if not impossible for the DMO to achieve savings.		
11.	Exhibit B. 4, Amounts Payable	2	DM is a long-term process for chronic illness. Once enrollment is achieved, members remain in the program. Because of the different lengths of the three contract periods (16, 12, and 15 months), members would have to be dropped for no other reason than unequal funding in the periods (i.e., $4 million for 16, then 12, then 15 months).	Each period should be 12 months long to promote access and continuity of care.	The RFP will not be revised to reflect each period is 12 months in length. The amounts payable as listed in Exhibit B, 4, p.2 of 4, each contain 12 months of billable time. The first budget period includes 4 months of implementation time which is not billable as no services are provided and 12 months of operational time which is billable. The second budget period contains 12 months of operational time which is billable.

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					The third budget period includes 12 months of Operational time which is billable, and 3 months of Phaseout time which is not billable. For a description of the contract periods, please see Exhibit E, 21, p.10 of 20. Definitions for the three periods are also provided in the glossary (Appendix 1).
12.	RFP Section D., Proposer Questions, No. 2, Question Deadline	9	It states that proposers have until "two working days before the pre-proposal conference date" to submit questions, i.e., September 12th. In the next sentence, there is a different deadline of today, September 1st.	The Proposer has developed substantive questions for the September 1 deadline, the September deadline should be accepted so that proposers have more time for in-depth review of the RFP and associated documents.	An addendum has been issued clarifying the dates and is available on the OMCP website on the HIV/AIDS DMPP download page under Administrative Bulletins/Addenda. The correction is listed as: Administrative Bulletin 1.
13.	RFP, Section K, Proposal Format, 2, Format Requirements, b.4	17	It states that the Forms and Appendix Sections need not be paginated.	Would numbered tabs identifying each form and appendix be appropriate?	Numbered tabs identifying each form and appendix are appropriate and acceptable.
14.	RFP, Section A.2. Background	7	The RFP indicates the DM program is provided through "an administrative model." Will DHS permit qualified providers rendering Medi-Cal covered services (fee-for-service or managed care) to beneficiaries with HIV/AIDS to provide DM	Establish specific safeguards to address actual or perceived conflict of interest.	A qualified Medi-Cal provider may be awarded the HIV/AIDS DMPP contract. There are multiple safeguards in place to prevent and/or address actual and potential conflicts of interest. First, all bidders are required to sign a Conflict of Interest Certificate (Attachment 17) that

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			services , including utilization monitoring under the terms of this contract? That is, how will DHS address actual or perceived conflict of interest regarding an existing provider's interactions and influence with beneficiaries, as well as access to sensitive beneficiary and [competing] provider data?		identifies potential conflicts of interest and provides a procedure for resolving conflicts of interest. Second, Exhibit E, provision 8, describes the procedure for "Avoidance of Conflicts of Interest by the Contractor." Third, the RFP requires the contractor to submit reports on enrollment/disenrollment, eligibility, and various quality/outcome measures. This data will be analyzed by the third party evaluator and results, including irregularities will be reported to CDHS. CDHS will review all results and will take appropriate action for any breach of contract terms and conditions by the contractor or their subcontractor. Lastly, California Welfare an Institutions Code, Section 14022 and 14030-14042, also known as the "Medi-Cal Conflict of Interest Law," provides a mechanism for disclosure of the interests of providers of service in the services, facilities and organizations to which they refer Medi-Cal recipients so that it is possible to determine the extent to which conflicts of interests may exist because of such referrals.
15.	RFP, Section J. Qualification Requirements	14	The RFP requires each Proposer to "certify and prove" that it meets	Please clarify what constitutes certification and	Certification will be provided through the Certification Checklist

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			required qualification, including experience and financial stability.	proof.	(Attachment 2). Proof will be provided through submission of Section K, proposal Format and Content Requirements.
16	Exhibit A, Section G.2. Enrollment/Disenrollment	15	Are children under 22 (who other than age meet the requirement) included beneficiaries if their mothers are covered?		No.
17.	Exhibit A, Section G.2. Enrollment/Disenrollment	16	Are beneficiaries residing in PHFs (less than 17 beds) or in mental Health Rehabilitation Facilities (MHRF) covered?		They are not eligible for this program if they are receiving comparable case management services.
18	RFP, Section K.3.i.2.b. Rate Proposal Section-General Instructions	27	The RFP indicates a case management fee per enrolled member, otherwise stated as "enrolled member who receives services."	Please clarify definition of enrolled member. Note Exhibit A--Scope of Work -- Section G.2 indicates enrollment in the DM program is on a voluntary (i.e. opt-in) basis. Does DHS plan to apply other criteria, in addition to consent to participate, in defining an enrolled member?	Yes, there will be additional criteria in the case of beneficiaries who may be referred or identified as potentially eligible through a process other than the monthly generated CDHS eligibility list. A beneficiary identified on the CDHS supplied list of eligible beneficiaries will be considered enrolled when consent to participate in the DMPP is obtained. All other beneficiaries will be considered enrolled when CDHS deems the beneficiary eligible to participate in the program and when consent to participate in the DMPP is obtained.
19	Appendix HIV Demographics		Can you provide data on number of covered beneficiaries by zip		No.

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			code?		
20.			Does CDHS intend that the HIV/AIDS DMPP be offered to eligible persons throughout the State, or do existing programs that provide comparable case management services and therefore restrict eligibility define the geographic area as well as the DMPP membership?		CDHS intends the HIV/AIDS DMPP to be offered to eligible persons throughout the state according to the eligibility criteria listed in the RFP. To our knowledge, no geographic areas are ineligible because of ongoing case management programs.
21.	Data Library		Will CDHS provide de-identified claims data for analysis so the proposers can include examples of system capabilities?		No.
22.	Data Library		Will CDHS provide claims data to the selected DMO prior to project implementation?		No. Claims data will be supplied for DM enrolled Members on a monthly basis during the operational periods.
23.			Will CDHS provide the contracted DMO with complete demographic data, including phone numbers, on the eligibility lists?		Only information that is determined to be relevant for outreach and enrollment, such as, but not limited to, telephone number, language, and address will be provided as part of the eligibility list.
24.	Exhibit A, Enrollment/Disenrollment	16	Is comparable case management just medical case management or does it include other kinds? How can you tell the definition of comparable and what kind may be comparable?		Comparable case management would include all forms of case management. See question #8 for more information.

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25.	Exhibit A, Scope of Work, G.2, Enrollment/Disenrollment	16	Listed as ineligible are beneficiaries who participate in Medicaid waiver program, including Home and Community Based services and other waiver programs. The Data Methodology provided in the Data Library notes that some AIDS waiver beneficiaries (or case months) may be included in the expenditure data. Are beneficiaries enrolled in other waiver programs excluded from beneficiary counts and expenditure data? Additionally, could you provide DHS' rationale for excluding HCBS waiver participants from the HIV/AIDS DMPP?		Beneficiaries enrolled in other waiver programs are not excluded from the beneficiary counts and expenditure data contained in the data library. CDHS is working on developing a program that will screen eligible beneficiaries from other California waiver programs and expects to have the program available by the time the DMPP becomes operational. However, it is the responsibility of the contractor to ensure their assessment process confirms a beneficiaries eligibility for the program following the criteria contained in Exhibit A, G.2, pp.16-17 (see question 24 above). There are a couple of reasons why beneficiaries enrolled in waiver programs are excluded from participation in the DMPP. First, beneficiaries are excluded to avoid duplication of services which can adversely affect coordination of care and reimbursement issues; second, beneficiaries are excluded from waiver programs so that financial and health outcomes can be attributed to interventions from the DMPP with minimal influence from external sources.

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26.	Exhibit A, Scope of Work, G.2, Enrollment/Disenrollment	16	Also listed as ineligible are beneficiaries receiving comparable case management services from another program, including but not limited to AIDS Case Management. Again, are these beneficiaries excluded from the Net Payments of Medi-Cal Claims for HIV/AIDS Beneficiaries by Claim Source provided in the Data Library?		No. At this time, there is no way of identifying beneficiaries receiving AIDS Case Management Services through administrative data therefore; the data may contain some expenditure for beneficiaries receiving this type of service.
27.	Exhibit A, Scope of Work, G.2, Enrollment/Disenrollment	16	This section indicates the eligible population will have a primary or secondary diagnosis of HIV/AIDS. As noted in the Data Methodology provided in the Data Library, this is a different criteria used for the beneficiary counts and expenditure data provided in the Data Library. Can DHS share your rationale for not continuing to use the Medstat Episode Grouper (MEG) as the basis for inclusion in the HIV/AIDS DMPP? Can DHS provide beneficiary counts and expenditure for the new inclusion criteria (i.e. Dx only) to potential bidders?		CDHS will use primary and secondary diagnosis codes 042 and V08 for eligibility and claims data runs as described in the RFP. A new data run has been performed using primary and secondary criteria. The data run will be announced in an addendum to the RFP and results posted in the data library. Data based on the MEG will be removed from the data library and all bids to the RFP must be based on the new data based on primary and secondary diagnosis criteria.

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28.	Exhibit A, Scope of Work, G.2, Enrollment/Disenrollment	15-16	This section addresses minimum enrollment quota. Can DHS share the desired minimum HIV/AIDS DMPP enrollment level with potential bidders prior to determination of a statistically valid sample size by the independent third party evaluator?		A precise number will depend on statistical calculations of each outcome measure, but approximately 500 beneficiaries will need to be enrolled for an effective evaluation of the program.
29.	Exhibit A, Scope of Work, G.2, Enrollment/Disenrollment,	17	This section states that members with a short term stay of thirty days or less in a nursing facility will not be disenrolled from the HIV/AIDS DMPP, while beneficiaries who reside in a nursing facility are ineligible. Do expenditures provided in the Data Library reflect only short-term nursing facility stays?		No. CDHS will re-run the data using nursing facility residence and intermediate care facility for the developmentally disabled residence as exclusionary criteria. If there is a significant change in the eligibility and/or claims data with the new criteria, an addendum will be issued.
30.	Exhibit B, Budget Detail and Payment Provisions, section 4.A,	2	This section indicates a portion of the $12 million budgeted for the HIV/AIDS DMPP may be allocated for a third-party evaluation contract. When does DHS anticipate this contract to be in place? Is there an estimate for the amount of funding required, and could you provide a brief overview of the scope of this evaluation contract?		The Evaluation contract will be in place before the contractor implementation phase. At this time, it is unlikely that any funds allocated to the HIV/AIDS DMPP will be used to procure the services of an evaluation contractor. Exhibit A, Scope of Work, C.6 Monitoring and Evaluation, contains a brief overview of the scope of the evaluation. In addition, the Evaluator will develop a written report of the findings of the

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					program to be presented to the Legislature at the conclusion of the Pilot Program.
31.	Exhibit B, Attachment I, Special Payment Provisions, 1. Contractor Risk in Providing Services	1	This section indicates the contractor will assume total risk providing the covered DM services. 3. Case management Fee Rates Constitute payment in Full, p.1 indicates case management fee rates constitute payment in full for all covered DM services. Would DHS share savings in claims costs with contractors based on findings of the independent evaluation?		No.
32.	Exhibit B, Attachment I, Special Payment Provisions, 6.B, Recovery of Case Management Fees	2	This section states that disallowances of federal financial participation (FFP) for Contractor's failure to comply with mandatory Federal Medicaid requirements may be recovered by CDHS by an offset of the case management fee to the contractor; Does DHS have all necessary authority from CMS and can DHS share these governing documents with potential bidders?		CMS has been notified of release of the HIV/AIDS RFP. Because the RFP is delivered through an administrative model, review and approval from CMS is an option and that option has not been exercised at this date. The RFP was developed without a SPA or waiver; therefore there are no governing documents of that type to share. In State Medicaid Director Letter #04-002, dated February 25, 2004, CMS states that, "A disease management program that is limited to administrative

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					activities by the state and its contractors would not constitute "medical assistance," but could be eligible for Federal matching funds for administration of the State plan at the standard administrative matching rate of 50 percent."
33.	Exhibit B, Attachment I, Special Payment Provisions, 8.C. Savings Guarantee and Calculation Methodology	3	This section addresses the savings guarantee and calculation methodology with respect to adjustments to baseline total costs. Can DHS describe the process for baseline adjustment to account for inflation and any other factors? Will DHS use historic trend rates and mechanisms to adjust for program and policy changes during the intervention period? At what point does DHS anticipate all these factors being known?		(Answer pending)
34.	Exhibit B, Attachment I, Special Payment Provisions, 8.C. Savings Guarantee and Calculation Methodology	4	This provision indicates actual costs are determined after a sufficient lag time for run out claims. Can DHS provide a specific schedule for the cost determinations? For example, actual claims incurred in the first 12 months of the operational period will be determined 18 months after the start of the		CDHS is looking at a 6 month lag time for claims to be submitted in calculating actual costs for each operational period, however this figure is subject to final determination by the third party evaluator.

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			operational period (assuming a six-month lag period).		
35.	Exhibit B, Attachment I, Special Payment Provisions, 8.D. Savings Guarantee and Calculation Methodology	4	This section indicates that cost comparisons are to be made on a per member, per month (PMPM) basis yet net payment of Medi-Cal claims for HIV/AIDS Beneficiaries by Claim Source provided in the Data Library do not reflect PMPM costs; Can DHS provide PMPM expenditure data for the eligible population to potential bidders?		No. The data provided is sufficiently detailed to be used in formulating a bid. PMPM expenditure data will be provided to the contractor once the program becomes operational.
36.	Exhibit B, Attachment I, Special Payment Provisions, 8.G. Savings Guarantee and Calculation Methodology	4	This section states the saving calculation is based on the expenses for the entire eligible population in the pilot area. Can you please confirm that the HIV/AIDS DMPPP is a statewide program as specified in Section 2 of Exhibit A? Can DHS provide beneficiary counts and expenditure data by geographic area to potential bidders?		The HIV/AIDS DMPP is a statewide program; however, to protect confidentiality, only aggregate data will be provided at this time.
37.	Exhibit A, Enrollment/Disenrollment	15	Has the eligibility list been screened for all exclusionary criteria and is there a process described in the RFP for identifying exclusionary criteria, or is it up to the contractor to		Eligible members have been screened for 6 of the 11 criteria listed in Exhibit A, 5.G.2. Eligible beneficiaries were not screened for the following criteria: • Are eligible as medicall needy

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			develop a system to screen eligible beneficiaries for exclusionary criteria?		(this criteria has been deleted. See question #7). • Have other health care coverage that provides comparable DM services. • Participate in Medicaid waiver programs, including Home and Community Based, (participants in the Aids waiver program have been excluded form the list of eligibles), Freedom of Choice and Research and Demonstration waivers, but not including the Hospital Financing/Mental Health waiver. • Receive comparable case management services from another program. • Receive services related to severe trauma (the most recent list of eligibles and claims data available on the OMCP HIV/AIDS DMPP website download page have been screened for services related to transplants, cancer, end stage renal disease, and hospice). •

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					CDHS is working on a program that will screen eligible beneficiaries for participation in a waiver program, however, it is an expectation that the contractor have a process for confirming all eligibility criteria as part of the assessment process described in Exhibit A, G.1.b, p. 15 and Exhibit A, G.2, p.17.
38.	Data Library		Does the figure 5400 represent the number of eligible enrollees?		Yes. See question #27.
39.			How will the initial list of enrollees be released to the contractor?		Release of the initial list will depend on the capability of the contractor. Details of the release will be an operational decision between CDHS and the contractor.
40.	Data Library		Was the eligibility list in the data library run using the ICD-9 code for AIDS and not the code for HIV?		See question # 27
41.	RFP, Section K.3.e.3 and 4	20-24	K.3.e.3 asks for work plans for those listed in K.3.e.4., and K.3.e.3.(a-f) are the same instructions as those on Attachment 13, the work plan. However, h) (p.21) is asking for a time line that is not in Attachment 13. Should we at this point in the narrative insert work plans, or do you want a narrative of what (more briefly) is attached as		Use the format of Attachment 13 to respond to the Work Plan Submission Requirements listed in section K.3.e.4 and add K.3.e.3.h (p.21) as an additional item after #7 of Attachment 13 (you may label this #8 on the format). The time/task line requested in item K.3.e.3.h should address each of the five Work Plan Submission Requirements listed in K.3.e.4 (i.e. MIS Plan, QIS Plan, UM

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			Attachment 13? Lastly, for K.3.e.3.h), should that time/task line combine all six required areas of the work plans, or should they be done for each area?		Plan, Member Services Plan, and Provider Services Plan).